PROPRIOCEPTIVE POSTURAL REFLEX TECHNICS

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The most useful of unconventional procedures is understood by very few chiropractors. Those few use it with many patients. It is better than a chemical muscle relaxant by being faster and much more specific to the problem muscle. It is also an excellent neural probe and a fine indicator to help locate the key subluxation. This improves clinical efficiency with any other technic used.

The auricular technic is not auriculotherapy. It is not a zone therapy. It is not acupuncture or any derivative. So what is it? It is a "Proprioceptive Postural Reflex Technic," effective for correcting distant subluxations.

How can tilting an ear move T6 or L3 and immediately ease peripheral pain and visceral malfunction? Research showed that the suboccipital muscles have about a tenfold richer and more definitive supply of proprioceptive endings than any other joint areas.[1] In humans this is most critical for upright posture and the related coordinations. These muscles have their nerve supply from C1 and C2. The human ears have auricularis muscles, with their own proprioceptive sensors. These muscles are also supplied from the same upper cervical segments.

Imagine a person who unexpectedly stepped from a curb. The jolt has subluxated and disturbed the head-neck level so that the head is now pulled forward on the right side by a hypertonic superior oblique muscle. The proprioceptive input is distorted so that the postural nerve centers cannot locate the exact fault and correct it quickly, as is usually done.[2] If I now lightly grasp the helix and tilt the ear forward, there will be increased tension on the auricularis posticus muscle behind that ear. The information input can be interpreted, "right ear is too far forward; pull it back." So the tight superior oblique relaxes, its opponent rectus capitis anticus muscle tightens, and the head is restored to its normal position. The subluxation has been improved.[3] If this correction is adequate to retune the distorted input, then the subluxation has been corrected and remains normal after the ear tilt is released. You have just indirectly moved the bone, rebalanced the muscles, corrected the joint subluxation, cleared the nerve interference and cleared some symptoms immediately. And it was done by hand.

If this entire scene was acute, then that procedure may be adequate for complete correction. If the injury was old, the muscles and ligaments have become stretched on the long side, shrunk on the short side and grown into a new pattern of adaptation. A thrust to stretch scar tissue and shortened ligaments is indicated. Repeated stretches are usually needed, with slower progress. However, the proprioceptive reflex technic by auricular tilting will start muscle rebalancing each time and make every other technic easier and better.

Now how can the ear tilt move T7? An old injury from a surprise slip while lifting may kink T7-8 level, with subsequent mild duodenal spasms, bile regurgitation, vagus irritation, reflex Occ-C1 subluxation and headache. This pattern is called migraine. Headaches very often come from Occ-C1 subluxation. Manual thrusts move the joint, but the subluxation often recurs in minutes, with a worse headache resulting. Why? Because the key subluxation is at T7 and was not corrected. Such patterns are called "subluxation interrelationships."[4]

Tilting this migraine person's ear in the optimum direction, as indicated by superior oblique muscle rebalancing, will greatly reduce the Occ-C1 subluxation within a few seconds. The headache will ease. Other reflex subluxations will simultaneously and dramatically improve. With the typical migraine patient the T7 will improve only 30% to 50% with just the ear tilt. The stubborn one and probably the key subluxation could be T3 or even T10. In this manner the precise and complete spinal monitoring — before, during and after the ear tilt — will pinpoint the key subluxation. After such a key T7 is thrust quickly and properly, the other subluxations will disappear and stay normal. Many such migraine patients clear quickly with only the T7 adjustment. This may need repetition two to 20 times. I have observed in my own practice that Occ-C1 may need only one or even no thrust after T7 is corrected. Such monitoring to locate the key subluxation improves clinical results.

A subluxation is a new and unstable neurological entity with all its neuromuscular imbalance, abnormal heat pattern, distorted visceral function and perverted sensations to its periphery, as well as symptomatic pain. The normal joint with the normal physiology is much more stable. Hence the one or even six spinal subluxations are like dominoes up on end. The normal spinal joints are like the stable dominoes lying flat. Jarring the table, shaking the floor or turning on a fan to blow across the table will be much more likely to stabilize everything by flattening the "on end" dominoes than it will be to upend the flat ones. It is generally easier to "fix" than to "unfix" spinal alignment. But of course one has to find the fault before one can fix it. Hence

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the need for palpation and nerve tracing, which are basic, fundamental arts to be continually practiced and improved.

The neurological mechanism of auricular correction is based upon distortion of the proprioceptive input. This distortion or detuning nullifies the normal, natural, rapid, postural reflex correction of any and every acute subluxation.[5] The auricular proprioceptive input can be precisely aimed to augment the normal postural reflexes and speed correction of any and all subluxations. And the indicator is the balanced tone of the Occ-C1 musculature.

PROCEDURE

Auricular Proprioceptive Postural Reflex Technic:

I. Patient standing:

A. First do observation of AP and lateral curves.

B. Check pelvic level (leg lengths) against a distant horizontal line.

C. Palpate while standing beside the patient with a three finger, gliding straight-edge, finger tips lightly touching each other, opposite hand supporting patient's forehead to aid relaxation and direct the motion.

1. Glide straight-edge over spinous tips from occiput to sacrum.

2. Glide over right and left side of spinous tips, noting laterality.

3. Check rotatore brevis muscle balance by gliding finger tip with skin vertically across the muscle. Hypertonic muscles are usually most tender or paresthetic at the insertion. Check other intrinsic muscles and trigger points in that nerve distribution. This is called nerve tracing when done from periphery to the spine.

4. Palpate Occ-C1-C2 during flexion-extension, lateral tilting and rotation of the head, opposite hand supporting the head and guiding head movement.

II. Patient sitting (classic Palmer method used from 1912):

A. Stand behind patient. Place forefinger of each hand on mastoid tip, ring finger (4) over the anterior tubercle of C1 transverse process.

1. Have patient thrust chin forward and move jaw laterally to right and left. Notice equal motions and comfort of movement.

2. Have patient look upward, chin forward to extend occiput on C1. Note mastoid-C1 motion for equality during extension. Repeat in flexion by dropping head forward and pulling in the chin.

3. With head erect, tilt head laterally to alternately raise and lower the right ear. Note mastoid-C1 motion.

4. With head erect, turn face left and then right to rotate Occ-C1. Notice mastoid-C1 motion for equality on both sides and at rest.

(The subluxation is not the resting position relative to the earth but relative to adjacent spinal segment. Subluxation is joint disrelationship, not the position of any one bone.)

III. Patient sitting (static and motion evaluation):

A. Stand beside the patient, one hand supporting and moving patient's head. This portion of the examination is bone palpation.

1. Place thumb against posterior margin of the near mastoid tip with the pad of the thumb over the posterior tubercle of C1 transverse process. The thumb is on two bones at one time. Place chiropractor's index finger tip (3d) against the posterior mastoid tip (far side) and finger pad against the posterior tubercle of C1 transverse process. Finger evaluating two bones.

2. Check positions and relative motion during flex.-ext. of Occ-C1.

3. Check positions and motion during lateral bending of Occ-C1.

4. Check same positions and motion during rotation of the head. (C1 TVP prominence may be an anomaly and not a subluxation. This is differentiated by the following muscle palpation.)

B. Same position, with one hand supporting patient's forehead.

1. With chiropractor's index finger fixed on the skin, glide the finger and skin horizontally across the fibers of superior oblique muscle, starting at the origin on TVP, then upward to horizontal glides at insertion into inferior nuchal line. These two points, origin and insertion, are the tender or paresthetic "trigger" points. The hypertonic muscle is tense, bulky and tender.

2. Do the same comparison of both right and left rectus posticus major, rectus minor and inferior oblique muscles. These are the muscles that maintain the subluxations when they are hypertonic.

3. Turn the head to the comfort maximum to uncover the origin of rectus anticus and rectus lateralis. Extreme tenderness of TVP muscle origin suggests hypertonicity, maintaining a subluxation.

C. Mentally visualize this Occ-C1 level of two separate joints with their intrinsic musculature. Normal conditions would be total symmetry of bone structure, of motion and of muscle action and tone. Subluxation would be alteration of all these items with complete correlation, plus tenderness along the peripheral distribution from the occlusion. Hence taut and tender superior oblique would pull occiput anterior and atlas posterior. Concurrently, the inferior oblique will contrarotate C1-2 and irritate the great occipital nerve (C2) up to the crown. Taut and tender rectus anticus will pull occiput posterior, C1 anterior, and irritate the posterior auricular nerve (C1) up over the ear and into the temple. C1-2 would be undisturbed. This is nerve tracing and integration of everything, static and motion, bone, muscle and nerve palpation.

IV. Patient prone:

A. Any significant subluxations should be verified in this position.

B. Note and record all subluxations from occiput to sacrum as in IC, including muscle palpation and nerve tracing to the periphery. (Now with the subluxation evaluation recorded and verified by vasomotor skin temperature changes, EMG or

other procedures, we are ready to do the following test.)

V. Locate the taut and tender superior oblique muscle with a finger tip to monitor changes in tone and tenderness.

A. With monitoring finger lightly in place, use the other hand to grasp the helix of the ear, same side (tight rt. sup. obl. = right ear).

B. Tilt the top of the ear backward. The elicited postural reflexes from auricularis muscle spindles will tighten the superior oblique. Tenderness is slightly increased, but may not be noticed.

C. Tilt the helix forward to increase proprioceptive input from the auricularis posticus muscle. This will induce relaxation of the superior oblique muscle.

(Usually there is a combination of muscle distortion maintaining the subluxation. The exact 90 degree vector, straight forward, seldom occurs. If the superior oblique, rectus lateralis and rectus anticus on the same side are equally hypertonic, the occiput will be laterally deviated with mastoid and C1 TVP approximated. In that case the optimum vector will be tipping the helix of the ear straight footward, caudad. Most persons will have an optimum ear vector forward and slightly footward. With the person standing, this would be about 4:00 o'clock vector from the center of the right ear. The exact optimum vector within an infinite number of directions will be found when the monitoring finger perceives good relaxation of the superior oblique muscle. If the superior oblique relaxes upon tipping toward 4:00 o'clock, then it will tighten by reversing the vector to 10:00 o'clock. Persons perceive this subtle change of tone with two or three such reversal demonstrations. The patient feels the change almost as soon as I can feel it, so there is no deception or imagination used here.)

D. Now monitor the rotatore brevis of each lower subluxation. Almost the same vector (within 10 degrees) of ear tilt will duplicate the better-worse tone change of muscle balance, down to and including L5. This moving of T10 or L3 by tilting an ear is astonishing.

E. Pull the helix very lightly in the optimum direction to relax the superior oblique. About one ounce of force is adequate. Then relax to zero pull. The very light intermittent tilt or pull in the same precise vector, about two repetitions per second for 30 seconds, will often induce dramatic correction of the subluxations, with improvement of all the peripheral tender points.

SUMMARY OF PROCEDURE

1. Locate and verify any and all subluxations.

2. Precisely determine Occ-C1 relationship. (Two condyle joints. Not C1-2.)

3. On side of taut superior oblique, tilt helix of the ear "around the clock," plus laterally away from the head. This gives thousands of vectors. The hundreds of possible muscle combinations maintaining the subluxations are thus covered adequately.

4. Relaxation of the superior oblique indicates optimum direction. Passing over that vector will produce a twitch or quiver under the monitoring finger. Refine the direction to achieve quiet relaxation.

5. Intermittent, light tugs, one or two per second, in the exact vector, induce more and more relaxation of tight muscles and increased tone of the opponent slack muscles.

6. By rotatore brevis monitoring of any other subluxations, repeat the procedure with minimal direction changes.

7. Come back and recheck all subluxations in a few minutes for recurrence and for key subluxation location.

8. The key subluxation needing a thrust will be the least responsive. After delivering such a thrust and a few minutes rest, many reflex subluxations will be gone and not recur. Recheck again for success.

SUMMARY

Proprioceptive input is distorted by significant subluxations.[2] Tilting an ear can alter proprioceptive input and induce corrective postural reflexes.[3] Improvement of the postural reflex integrity allows the body to do its own subluxation correction, often with no thrusts.[2] Such auricular proprioceptive postural reflex procedures can induce enough relaxation to make any other technic easier and more effective. This reflex procedure also helps to pinpoint the key subluxation. This reflex procedure is monitored first by rebalancing superior oblique muscle tone. It is a subtle change, requiring much practice for best efficiency. Patients can use this by themselves as a first-aid procedure, preventing subluxation aggravation by excessive intrinsic muscle hypertonicity. As such, this auricular proprioceptive procedure increases clinical efficiency. Another of the proprioceptive postural reflex technics is actuated by a light pelvic contact and has almost identical mechanisms and equivalent applications. ■

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PRECISION PALPATION &

PERIANAL POSTURAL REFLEX PROCEDURE

EXAMINATION:

Patient standing:

Observe - from oblique - on variations of the AP curves and head position.
- from posterior - head tilt, shoulder height, scolioses and pelvic tilt. Note pelvic sway to side of midline.

Palpate - while crouching behind the patient visually using the floor-wall line as a straight-edge note bilateral comparison of: iliac crest levels, PSIS, ASIS and femoral trochanter levels.

Standing beside the patient with 3 finger straight edge gliding move, from occipital protuberance to coccyx, opposite hand supporting patients forehead to allow optimum relaxation and to direct motion.

1. over spinous tips, counting and noting prominence,
2. over right and left side of spinous tips noting laterality,
3. rechecking rotatore balance. Where a taut, tender rotatore is noted check other intrinsic muscles and nerve trigger points within that segmental distribution (vertemere) Also called nerve tracing when done from periphery to the spine.
4. postural twisting and bending to check on foraminal occlusion.

Still standing beside patient palpate Occ-C1-C2 during flexion-extension, lateral tilt and rotation of the head; the opposite hand supporting and guiding forehead position.

Patient Sitting:

Stand behind patient. Place forefinger of each hand on mastoid tip, ring finger (4th) against ramus of mandible and "Chiropractor's Index" (3d) finger over the anterior tubercle of C1 transverse process. Note prominence and position of C1 transverse relative to mastoid and to mandible. Have patient thrust chin forward and move jaw laterally to right and left. Notice equal motions. Have patient look upward with chin forward to extend occiput on C1. Note C1-mastoid motion for equality. Have patient flex Occ on C1. Now with head erect have patient tilt head laterally to alternately raise and lower the right ear. Note mastoid-C1 motion. With head erect rotate head to right and left. Note mastoid-C1 motion and position at rest. The subluxation is NOT the resting position relative to the earth but relative to the adjacent spinal segment. The subluxation is the joint disrelationship.

Stand at patients right shoulder, forehead pressing your right hand. With the three finger straightedge glide from EOP down to sacrum. Now double check the upper cervical position and motion with patient sitting.

Next palpate with the same gliding straightedge the bifurcations of cervical spinous processes. Then glide along the articular processes to note prominence. Next with the same position check the rotatore and longitudinal muscles which would verify or modify the listings. Next while standing beside the patient, place the thumb against the posterior margin of the right mastoid tip with the pad of the thumb over the posterior tubercle of C1 transverse process. Place the chiropractor's index finger against the posterior of left mastoid tip with the finger pad over posterior tubercle of left C1 transverse. Now Flexion and extension of occiput on C1, lateral bending and rotation of the head will add much valuable information.

Examination (continued)

Now standing beside the patient's shoulder palpate the length of the intrinsic suboccipital muscles and compare their tone; superior and inferior oblique, left rectus major and minor from the posterior. To evaluate the rectus lateralis turn the head to the right to uncover the anterior portion of left transverse process, C1 and the muscle which pulls it forward. Increased sensitivity will suggest hypertonicity.
The remainder of the lower cervical spine should be checked for bone alignment, intrinsic muscle imbalance, nerve tracing and limitations of motion. Compression tests often aggravate symptoms and traction often relieves them.

Similar double checking can be done in the thoracic and lumbar region but with the patient sitting the dorsal muscles are pulled too tight for best palpation.

Patient Prone -

Any significant subluxations should be verified in this position. Further evaluation can be done with gently pushing the spine laterally with a side to side rocking motion to evaluate freedom or loss of motion. This in addition to bone palpation, muscle palpation and nerve tracing will verify or mofify listings done with the patient standing and sitting. Any subluxations should be noted and rechecked for evaluation during the following reflex testing.

TEST PROCEDURE:

Closely examine L5-S1 relationship. Any laterality of L5 spinous will be caused by tension of a rotatore muscle. Digital palpation of the rotatores at their insertion will show a slack, soft muscle on one side and a taut, hard, ropey, tender muscle against the side of spinous process laterality. There is consistently a tenderness or paresthesia on this side of spinous tip which will be the most helpful indicator of postural reflex effectiveness. If the right side of L5 spinous is tender with a ropey rotatore proceed with a perianal contact. (right)

CONTACT:

Location is ideally about 1 inch distal to the tip of coccyx and then about one inch lateral of midline. This will place one at the gluteal crease. With many patients a light pressure toward the point of the shoulder this will bring the finger tip pressure against resistence of sacro-tuberous ligament. Standing beside the patient on the side of L5 spinous laterality is most convenient for most persons because the other hand can palpate the intrinsic muscles up to and including Occ-C1 level.

DIRECTION AND PRESSURE:

The finger tip pressure should be no more than can be comfortably be borne against one's eyelid. The direction of force is determined by intrinsic muscle tone. Once the optimum direction is located a pulsating pressure varying from zero to about four ounces of pressure is most effective.

Direction is started toward the shoulder and gradually turned with the finger pointing directly lateral but still horizontal. If there is no relaxation of the L5 rotatore muscle during that sweep then raise the angle to about 15° above and sweep back to headward. Another raise of angle with a lateral sweep and still higher to almost directly toward the ceiling will cover one quadrant. Someplace along this sweep there is usually a flick, a quiver of tone in L5 rotatore. Back to that lateral angle and then sweep vertically. A person with a deep lordosis will respond best to a ventral direction, even

Direction (cont'd)

with the direction almost directly down toward the floor but with the optimum lateral angle. Thus the optimum may be 45° lateral and 60° ventral with a deep lordosis. With a lumbago and a straight lumbar spine the optimum may be 30° lateral and 45° dorsal (up toward the ceiling).

When this optimum direction for L5 rotatore is located a light pulsating pressure can be used for about 10-15 seconds. By that time there should be a great relaxation of the tight L5 rotatore and a tightening of the slack one on the opposite side.

Now move the monitoring hand up to the next subluxation, check the rotatore which was tight. It will be considerably more normal already. A very slight change in direction (same contact point on same side as before) will finish most of the muscle rebalancing. Repeat this on up to Occiput. If all the subluxations have completely cleared leave the patient resting for a few minutes and recheck the muscle tone at the critical points. If any have have recurred or one did not clear before that one will likely be the KEY subluxation and will respond best to a direct thrust.

PURPOSE:

As a test procedure this method is used to eliminate the minor reflex subluxations and locate the one KEY subluxation which may require a thrust. This test procedure can be used to re-evaluate any adjustment done with a thrust, both immediately and on subsequent visits. This is a great help in determining patient progress in spite of major symptom change or persistence.

As a total practice procedure this is effective with some persons, mostly among the frail or sensative persons who do not tolerate heavy thrust as well. In patients with fractures or other pathology the subluxations can often be cleared to allow much faster healing without any possibility of traumatic damage.

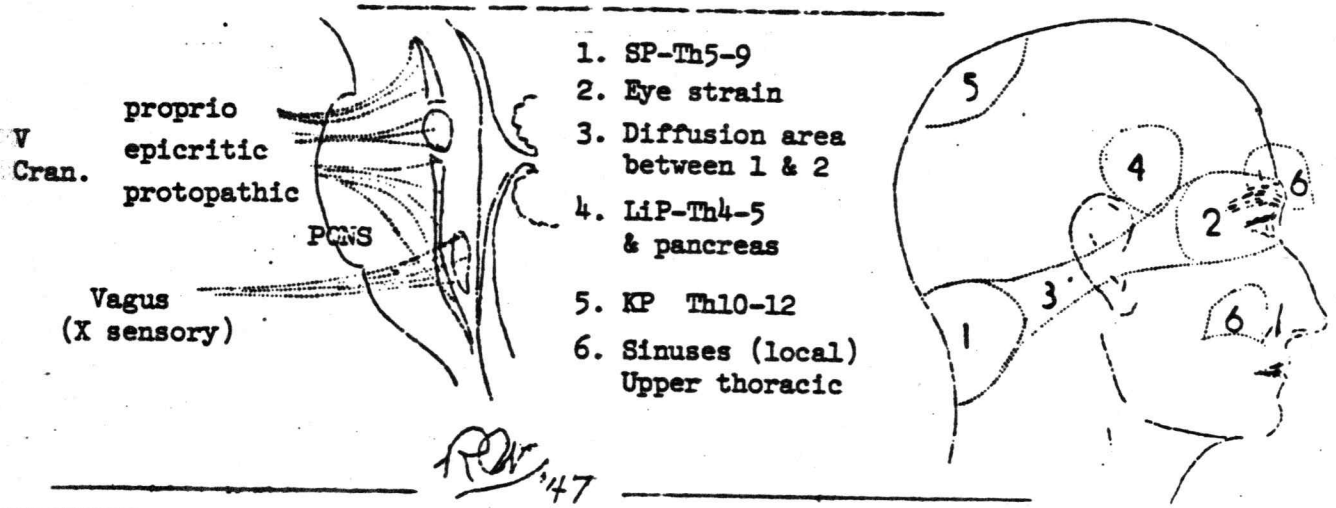
SUMMARY:

Locate significant subluxations and note them for clearance.
Determine L5-S1 position and rotatore balance.
Contact on gluteal crease; side of L5 rotatore tension and tenderness.
Find direction of LIGHT force by rotatore relaxation.
Repeat on up to Occiput-C1 with superior oblique as most convenient indicator.
Use LIGHT pulsating pressure in optimum direction until maximum balance.
Locate KEY vertebra to be thrust. The least responsive subluxation is the KEY.
Recheck all significant tender imbalanced points for best results.
Once a right (or left) contact, always a right (left) contact, for any subluxation in ANY direction above L5. Only rare exceptions. Regardless of the injury or disease, this same pattern usually exists and the same contact will be best. True, the direction of light pulsating force may vary slightly but the side of contact rarely needs to be changed.

R.W. 5.76

HEADACHES - RJW

MECHANISM The parenchyma of the brain, most of the meninges, the ependyma and the choroid plexuses are insensitive to pain. The pain sensitive structures are the venous sinuses and the arteries. They respond to pain ONLY by STRETCHING. This can be from pressures of tumors or other traction. Usually it is the result of excessibe vasodilation due to adjacent inflammation or to neurogenic sources. Many of these are induced reflexly or more correctly by "shunting" from the vagus sensory nuvleus to the descending portion of the trigeminal nucleus. Therefore those "spillovers" or "shunts" will affect adjacent levels of these nuclei to induce headaches from thoraco-abdominal faults. (often from thoracic subluxations)



PATTERNS Due to the reciprocal action through these interconnecte, adjacent nuclei, the patterns will generally follow the above diagram. A functional gastritis will initiate sensory vagal stimuli to induce adaptative corrections. Here the thoracic nerve sypply is often indadequate to handle the situation so it persists and the vagal stimuli become violent. To cut off this "jangling" the atlas may move forward to impinge upon the vagus as it leaves the jugular foramen. This not only cuts down the sensory stimuli but causes local vasomotor malfunction (sup. cerv. ganglion) with dilation and the consequent occipital headache.

These vagal stimuli often spread into the trigeminal nucleus viea the intercalated neurons. These secondarily will induce adaptative corrections for the simulated "eye injury". The effect will be ocular vasodilation resulting in stretch pain in the vessels behind the eyes. This area (2) will tend to fuse with the occipital headache (1) to five a general "basal" headache. Reciprocal action from initial eyestrain will give the same pattern in reverse. Hence, it becomes necessary to establish the order of the onset in order to differentiate the two divergent causes of the same pattern.

Hepatitis, cholecystitis or pancreatitis will send up vagal stimuli to the next level of the sensory vagus nucleus. This by the same mechanism occasionally initiates an occipital headache. Usually, however, it operates directly through the trigeminal nucleus to induce "bitemporal" headache (4).

Nephritis or other irritation in the sphere of "KP" influence usually induces a "vertex" headache (5). This is a relatively uncommon pattern.

The pain of sinusitis begins and usually remains quite localized. It is due to high or low pressure within the sinus due to inflammation and duct blockade. Since the mucosa of the sinuses and their ducts receive most of the nerve supply from the first two thoracic segments, an added stimulus here will induce mucosal vasoconstriction with shrinkage and the consequent pressure release. Occasionally, percussion of the axis will directly stimulate the superior cervical ganglion with similar results. This page is to help you find the primary, the "key" subluxation.

Aquarian Age Healing, Logan Basic Technic, much of SOT and several zone therapies are actuated by LIGHT contacts medial to the ischial tuberosity. Even coccygeal adjusting and rectal dilation use pelvic contacts. Each makes a different explanation but is it not possible that all such contacts work through the same mechanism? This fascinating thought is now history.

PERIANAL POSTURAL REFLEX TECHNIC

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Dialogue in 1947 with Dr. J. R. Verner, faculty of Eastern Institute and later CINY started the idea that a common neurological mechanism is probable with all such light pelvic contacts. If this be the case was it possible to discover the same mechanism in lower animals? Research? Yes. Since A cow's leg can reach a long way it seemed discrete to use a fork handle to reach out and make a light contact touching the perianal region just medial to the ischial tuberosity. If a light contact is made lateral to the ischial tuberosity, the pelvis was noted to move AWAY from the contact. If the contact is medial to the tuberosity the pelvis consistently moved TOWARD the contact. WHY? This resulting action was consistent and induced still more interest in the mechanism involved. The next project???

With an obese patient prone on the table and relaxed the lumbar spinal groove was observed as a light contact was made on the gluteal crease about midway between the ischial tuberosity and the rectum. (A - Fig. 1) Invariably there was a shift in the lumbar musculature swinging the sacrum apex TOWARD the contact. This tone was maintained during the contact whether 5 seconds or 45 minutes. As the contact was removed there was about a one second lag in the postural shift. With a contact changed to the opposite side a reversal of the lumbar spine occurred to produce a scoliosis swinging the sacrum apex toward the contact. (Fig. 2)

These observations culminated in a hypothesis which was published in the NCA Journal of August, 1948 as ANTHROPOLOGY IN REFLEX TECHNICS beginning with the "Phyogeny of Sex." From the simple fission and budding of unicellular forms we followed the elaboration of sexual reproduction which became more highly specialized. To conserve sperm and to facilitate copulation postural reflexes are very practical. In the cloacal stage the centering mechanism is probably actuated from pericloacal sensory endings. Since human beings have genital and alimentary separation, the conscious erotic zone is genital centered. The subcortical sexual postural reflexes are anal centered and are activated by light perianal contacts. THESE PREPOTENT POSTURAL REFLEXES are the NEUROLOGICAL BASIS OF ALL PELVIC REFLEX TECHNICS. Of course, there are many who will deny this quite vehemently. If one theory requires several rules with numerous exception and requires from 5 to 45 minutes to achieve results while another theory has only one rule with no exceptions and can be demonstrated consistently in 5 seconds, which would be more practical? One might ask how "crossing" lines of mechanical force which are pushing segments "into place" can explain the quiet orgasm with no preliminary excitation which is occasionally encountered? Why also, do so many patients with the best results often sigh and immediately drop to sleep? However, let us do further testing as clinical research.

If this mechanism of postural change works consistently with standing quadrupeds and with prone bipeds will it also work with a standing biped? While discussing this mechanism with a prominent chiropractor he was asked to stand and to palpate his own atlas. With him leaning back lightly to reflex the posterior lumbar muscles, the L5 rotatores muscle balance was palpated in order to choose the side of contact. Then with him standing normally the light perianal contact was maintained. The direction of force was varied while he held his finger tips lightly on the inferior oblique muscles from C1 to C2. He was asked to report when there was a change in tone. With monentary changes of direction to make a slow sweep through the quadrant he suddenly said, "There." With very minute changes in direction around that line of force he suddenly said, "It is completely gone." This entire procedure of atlas subluxation correction took about 45 seconds. The contact was held about another minute while further explaining the mechanism to another chiropractor in the same room. That ended the "treatment."

The "patient" then volunteered that he did have a headache all day long but had considered it to be a "sinus" headache which had been common with him. Immediately after this standing perianal contact the headache was gone and his head was not only free from pain but it seemed that a "fog had lifted" and that he could think more clearly. Eleven months later he was asked about the headaches. He chuckled and said that he had only occasional minor discomfort since that adjustment. Some persons say, "But since that is just a reflex it will only last while you hold the contact and can be only temporary." The results, however are seen to last from 30 seconds to 30 years just like any other adjustment. The duration depends upon the neurological state of the patient and the proficiency of the adjustor "monitoring" muscle tone. Dr. J. A. Henderson, the first registrar of

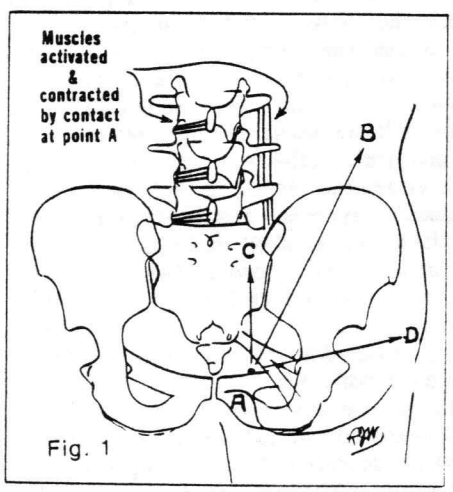

Fig. 1

CMCC, volunteered to be a "guinea pig" at Indianapolis, Indiana in 1936 for Dr. Heintze of Pensacola, Florida. Dr. Henderson admitted that it was unfair because the test feature, the pain in his wrist, had been constant since a fracture some 20 years earlier. Dr. Heintze said, "Let's not be hasty but first let us evaluate the problem." He took a contact and completed the demonstration. Dr. Henderson told me of this in 1950 and said that the wrist stopped hurting immediately and had not hurt once in the intervening 14 years. Don't underestimate the technic. The application may not be correct at first but the technic should not be sold short.

Dr. H. B. Logan insisted that a LIGHT contact be used. He denied being the first to use a light contact but did claim to be the first with a workable explanation. Many have thought, unfortunately, that if a little push is good a big push is better. Some have used heavy pressure until the thumb is numb. There are occasional reasons for such slow, heavy pressures but if the thumb goes numb, so do the sensory endings and the purpose of postural reflexes is defeated completely. Even though many will deny that reflexes are utilized and that the effects are strictly mechanical you are invited to try these procedures and to evaluate them.

One may say, "So it worked twice, how do I use it?" First of all, you don't need to practice on cows. Neither do you have to keep the patient standing and adjust the hard way. Most patients can lie down. This technic does work well with the patient supine or on the side but it is much easier with the patient prone. The theoretical background of sexual phylogeny is interesting and does help to explain some previously perplexing side effects but such knowledge is not essential in order to use the technic effectively. Obviously stoic patients will be least responsive and the hypersensitive patients will be most responsive to such postural reflexes. The most responsive are the acutely ill with their generalized hypersensitivity. Likewise, these same sick patients are easily upset with heavier technics. Now to the application of the mechanism.

Nearly everyone wants research data and "proof". Fine, don't believe anything just because someone said it. Test the procedure. Either prove or disprove the proposal. Then believe the results and apply them accordingly. If one wishes to start in the stable as mentioned go right ahead. Use a smooth tip on the fork handle and relatively light pressure. This would be less than eight ounces of pressure. If you prefer human patients you will find that it is not mandatory to make the contact on bare skin although it is usually more effective than through cloth. Two layers of nylon are too slippery to be effective. One layer of cloth may be better than none, especially in warm weather. With a nearly normal, flexible spinal column a shift in the spinal groove will be quite readily noticeable. An obese patient may well exhibit a shift of the midlumbar spine of two inches from a right to a left contact. Disregarding lifts at this stage, it is generally agreed that a right scoliosis will respond best to a right contact since the sacrum apex will move toward the contact. This is accomplished by activating the longitudinal muscles (intertransversals) on the side of the contact. Some insist on using a thumb contact while sitting beside the patient but others find it much more effective to use a finger tip contact while standing in order to easily reach and to effectively monitor with the other hand the changes of intrinsic muscle tone as far as the suboccipital area. The general rule will be to use no more pressure on the contact than is tolerable on the eye through the lid. That is only a few ounces of pressure and has been found to be much more effective than a heavier pressure.

The most potent postural reflexes are elicited with this light contact just under the sacro-tuberous ligament which is a very convenient landmark. Nearly the same response can be elicited along the gluteal crease. A contact too near to the ischial tuberosity elicits weaker response, while nearer to the anus a stronger response. However, being too near to the anus elicits different responses. Contact too close to the side of the coccyx seems very uncomfortable to some patients. If a poor response is noted a slight change of contact point, perhaps only 1/4 inch, will help greatly.

One may by now have decided that the contact on the low side of the pelvis, the side of the anatomical short leg is correct. This is usually true but many patients have almost no tilt. Iliac crest level is altered by many factors. With patients of the level pelvis type, one can palpate the L5-S1 relationship, particularly the tone of the rotatores muscles. These extend almost directly lateral from L5 spinous process and can be palpated best very close against the spinous process at their insertions. The tensed muscle will usually show paresthesias or tenderness at its insertion. Since these are synergistic with the intertransversalis on the opposite side, the choice of contact is easy. Tender right side of L5 spinous indicates a right perianal contact. This will activate the right longitudinal muscles (intertransversalis) activate the left transverse muscles (rotatores) while relaxing their opponents. This action takes place in the lowest scoliosis. Don't change sides for compensatory scoliosis above. They respond to the same contact most effectively. Consider for a moment the number of intrinsic spinal muscles from the sacrum to the occiput. Now consider the number of directions (radii) in the quadrant from headward to directly lateral and directly toward the ceiling. Instead of an empirical direction choice one may find the optimum direction quickly IF the isolated hypertonic muscles are monitored. Many find that with a very light finger tip contact on the hypertonic muscle, just to detect change in tone, the critical monitoring becomes very easy. A light perianal contact is made (at A, Fig. 1) with the direction of force toward the shoulder. (B, Fig. 1) Changes of direction are made in many radii of the quadrant. One can start with a horizontal sweep of directions of

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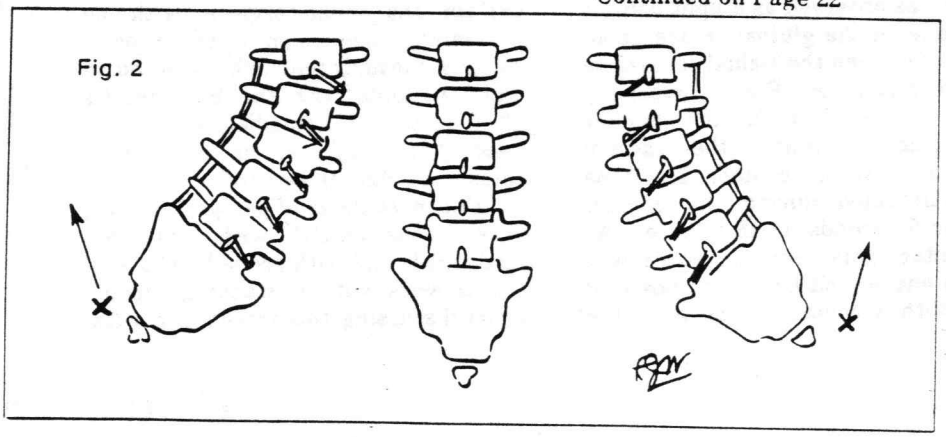

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force through this same contact point (A) from headward (C) to lateral, (D) then elevate about 30° and reverse the slow sweep, elevate to 60° dorsal and sweep lateral again. It is common to find a definite response with 5 seconds. If that response of relaxation of the hypertonic rotatores is noted at 45° lateral and 30° dorsal (toward the ceiling) then small changes of only a few degrees will usually locate the optimum response within another few seconds. It may be at 42° and 28°. Next, one can move the monitoring finger from the relaxing muscle onto the opponent muscle and usually find the tone of the opponent muscles reversed with the spinous process moving readily. If the tense muslce is too tender to touch, one can monitor only over the flaccid muscle, but then the sweep must be made a bit more slowly because of the slower perceptable response. Hypertonic muscles commonly reflex noticably within a fraction of a second when the optimum direction of the contact finger is achieved. Hence one full minute is more than ample to achieve excellent response in most cases.

One outstanding example of the effectiveness of this technic was a patient with verified multiple sclerosis, bilateral positive Babinski, many paresthesias, visual disturbances, unable to run for years and with much trouble walking. Routine adjustments had arrested the progress and everyone was happy with the arrest. With vasomotor monitoring they discovered that much was still wrong. A perianal contact for about two minutes cleared the cold areas and then someone wanted to observe the Babinski, which he had not seen clearly. Recheck showed a normal plantar reflex in both feet. It would be ridiculous to claim to have cured multiple sclerosis because the classic explanation is that of scar tissue islands in the brain and cord. Scar tissue certainly does not clear that quickly so the problem was that of neural dormancy, clinically identical to scars. A localized hypemia (or hypoemia) can maintain life in the special cells like neurons but precludes their specialized functioning. This can be caused by localized angiospasms, a vasomotor nerve phenomenon. This M.S. patient had been so diagnosed by specialists and still made this fantastic recovery. It is not fair to say that it was psycho-somatic because of the duration and other circumstances. Hence is it not reasonable to consider that islands of neural DORMANCY can and do exist? There is no instant change from normal tissue to scar tissue so why cannot the intermediate state of NEURAL DORMANCY persist for months or even years? Clinical results indicate that it is possible. Now back to our MS patient who just minutes ago had positive Babinski sign and now it is normal. So we have him get up from the adjusting table following the light perianal contact. The patient then wanted to walk outside and proceeded to RUN to the corner and back. This was the first time he had been able to run for over two years. Excellent recovery, but about a week later came a relapse. I personally saw the patient a few months later. After checking, a right perianal contact was used. L5 muscle balance was almost immediate. With only slight changes in direction with the same contact all other tender spots cleared within one minute. Atlas muscle imbalance cleared but not completely. After 1-1/2 minutes C1 was still a bit tender with the right superior oblique at fault. A light thrust was made on C1 and the perianal contact resumed. Temperature improved but it took two more minutes before the ideal temperature balance appeared. The

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patient arose with the entire right leg tingling and with tears in his eyes. Don't sell this technic short. It seldom works this dramatically on the first attempt. Baseball players don't usually expect to make a home run on the first pitch either.

Suppose that L5 is ideal and all is well up to T12. If the right side of T12 spinous is paresthetic, a right contact is indicated. Very seldom is it necessary to go so far up the spine to obtain a working indicator. Usually there is a noticeable imbalance in the tone of the L5 rotatores brevis pair of muscles. A few persons will show an imbalance of L4 more easily but most will be easily monitored by comparing the two sides of L5 spinous for muscle tone directly lateral, like a transverse band with a tender insertion. If the right rotator is tighter and more sensitive at the insertion a right contact is indicated.

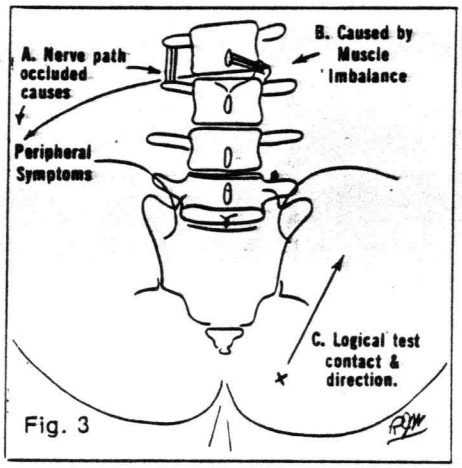

Fig. 3

Figure 3 shows an example of L2-3 subluxation and correction. As soon as the intrinsic muscles are balanced, the tenderness subsides. Then monitor the next higher problem and very slightly change the direction of force with the same contact. In fact, once the side of contact for a person has been properly determined there is almost never any reason to change sides of contact. One will have to change directions slightly but will not need to change sides of contact. With a little practice many chiropractors are now able to move an atlas effectively within 10 seconds. They release the contact and recheck again after about one minute. If muscle imbalance is renewing, a light thrust may be needed on the one most stubborn area. Usually they are able to clear the minor imbalances quickly and find the one articulation which is probably the old trouble maker, the major. It may well be an obscure subluxation that was previously missed or passed over lightly.

After working with this mechanism for some time it will be seen to be most effective, sometimes as the entire adjustment, sometimes as eliminating the minor problems and pinpointing the critical difficulty, or finally as a "finishing touch" to hold everything at its best after being "stirred up" with a heavier adjustment. Instead of taking 20 minutes for each visit, many are now finding that this is a time saver by eliminating much of the hunting and by quickly pinpointing the real problem. Please don't sell this technic short.

Some have used an intra-anal contact effectively but with several different explainations. Coccygeal "adjusting" may be more understandable and much more effective after this consideration of postural reflexes. With monitoring of intrinsic muscle tone the clinical results for many have improved considerably.

It is worth one week of effort to prove or disprove. After that check period on the lateral curves it may be checked with AP curves and give the first relief of the stubborn L5-S1 tenderness with the direction of force in the quadrant tilted ventral toward the floor. Clear the lateral curves quickly with the contact choice and then promptly tilt the direction of force into the ventral quadrant. It has been thought by some that an anterior or ventral direction of force would be harmful. With the angular hyperlordosis of L5-S1 this ventral direction is most helpful. Actually the majority of patients with low back pains will respond more quickly to this ventral tilt contact with the force downward toward the floor. Find the optimum direction of lateral force and then tilt the finger tip downward until maximum rotator response is noted. Some will call it magic.

SUMMARY: Prepotent, postural reflexes are initiated by light perianal contact. The sacrum apex moves toward the contact. Side of contact is determined by the low side of the pelvis or by the side of lowest spinous process tenderness. Optimum direction of this light force is determined by monitoring intrinsic muscle imbalance (usually lumbar rotator). Perianal, postural reflexes are excellent as a total method of practice or as a preparation for any other adjustment indicated. If muscle balance is not improving within 2 seconds, change direction. Effects of health improvement may last for many years from a single adjustment if timed properly.

Auricular Proprioceptive Reflex Technique...

R. J. Watkins, D.C. Dean of Graduate Studies Canadian Mem. Chiropractic College

DR. R. J. WATKINS

One of the most fascinating reflex techniques is quite bizarre at first glance since it involves pulling a patient's ear. In order to understand the mechanism quite thoroughly it is necessary for us to first briefly discuss a bit of neurophysiology. This can be explained simply as related to blinking the eye or moving from a hot stove. The establishment of any reflex pattern is dependent on the summation of impulses. The first stimulus across any synapse as a new unused pathway with a relatively wide spacing between neurons means that it will require not just one impulse but a series of several impulses made in a very short time in order to bridge the gap of the synapse and effect the response. In addition to the chemical mediator of the synaptic transmission there is also a growth factor which induces a definite physiological growth to close the synapse more securely. This is known as neurobiotaxis and is the anatomical basis of any habit formation. Each successive impulse will then find an easier transmission across the synapse and in the psychologists' terminology a "well worn neural groove" is thereby established. In this manner any well-established habit pattern becomes extremely stable and easily actuated.

Spatial summation is another factor in the actuation of any neurological mechanism. If there are ten different neurons converging upon one final effector as the usual case with the lower motor neuron, a single impulse from one single neuron may not cause the response of the effector. It is entirely possible that the summation of several converging stimulii at the same time will cause a complete response of the final common pathway in this motor neuron. It is also entirely possible to conceive of one motor unit with the single neuron and its several final muscle fibres doing an action which will cause a very weak response in the entire muscle bundle, since action with one per cent of the fibres within one muscle will not cause the same effect as a contraction of 100% of all these muscle fibres. Here again, is another more expanded concept of the spatial summation of impulses. Neck righting reflexes are the basis by which the cat is able to land on his feet when pushed off the porch roof. When the head is righted in response to the vestibular sensation it is at once noted in the nervous system that the cervical spine is not properly aligned. This misalignment is perceived through the proprioceptive endings primarily from the muscle spindles in the cervical area. This total neural image of the position of the neck muscles is interpreted through the centres in the brain stem clearing the proprioceptive stimulii. If then we have a subluxation anywhere in the spinal column, especially in the upper cervical region, we will have an imbalance of proprioceptive stimulii of which the brain stem is definitely aware.

Introduction of new proprioceptive stimulii to this upper cervical sensorial bed in the proper amount and the optimum character then will induce this cervical spine to make the necessary adaptation to the change of stimulii. Recall for a moment that there are several muscles around the ear, and that each of these does have muscle spindles as a part of the proprioceptive system. The very simple matter of tilting the ear with a finger will change the tension on these various muscles and induce change of sensation in the cervical cord. For comfort, convenience and maximum effect it is a simple matter to grasp the helix of the ear very lightly with the thumb and the forefinger, and then pull lightly in one after another radius round a circle. If for example the tension at the 10 o'clock radius induces an aggravation of the cervical subluxation which can be easily monitored by intrinsic muscle palpation with the free hand then the opposite radius at perhaps 4 o'clock will usually cause an immediate improvement in the position of the subluxation. It is clinically possible then to completely reverse the rotation of an axis spinous for example within a short period of one minute or less. The mechanism of thereby moving a vertebral segment with a light manual pressure on the ear which in turn can, and does cause a definite change in symptoms, is certainly within the realm of chiropractic. Based upon the above mentioned neurological process this is thereby entitled, "auricular proprioceptive technique".

This auricular proprioceptive technique is not only capable of properly changing the position of the upper cervical vertebra but also of affecting any subluxation in the spinal column with a diminishing effect as the distance increases. However, due to the relative instability of a very recent subluxation it is entirely possible to move even a lumbo-sacral disrelationship with this auricular proprioceptive contact. A person may well ask then which ear is the most appropriate to begin the desired effect. There is occasionally a definite difference of effect of stimulii of the right or left ear but until further statistical information is compiled it is suggested one use whichever ear is most accessible as a beginning. If, within 30 seconds time, the desired effect is not obtained then use the same mechanism with the opposite ear which may well work much better. As soon as the desired change of intrinsic muscular tension is accomplished in the upper cervical region which is often of the obliquus capitus group, then a very slight change of direction of tension upon the ear may well change the similar tensions in subsequent subluxations further down the spinal column. Very dramatic results have been recorded from this technique of adjusting the spinal column.

Due to the conditioned reflexes of society in general and their anticipated services from the chiropractic profession, it is not recommended that this technique of auricular proprioceptive contact be used as a major method of practice at this time. Where the more conventional methods are not completely adequate it is strongly suggested that this reflex technique be utilized.

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Dr. Watkins on . . .

"EAR-PULLING"

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When the patient is curious about the method of approach it is entirely feasible to mention that the mechanism is similar to that by which the eye blinks when someone waves a hand in front of the face, or by which a person jerks away from a hot stove even before feeling the burn. It is one additional way of helping the nervous system to establish normal adaptability and the optimum state of health.

A very recent example was a girl in an auto rear end crash. The atlanto-occipital articulation reversed its flexion-extension action, opening when it should close and vice versa. This was largely reflex from T-9 and L-S subluxations plus local soft tissue trauma. Usual adjusting brought very little relief. Light pull on the left ear toward 8 o'clock (angle of jaw) but laterally about 30° brought immediate relief, (3 seconds) clearance of T - 9 muscle imbalance and tenderness. Forty five seconds of this auricular traction (helix toward angle of jaw) resulted in complete clinical recovery of suboccipital headache, within one hour. It has not recurred in three weeks with only one more interim recheck.

The patient may inquire, so I tell them that by knowing more of the nervous system we can induce their own muscles to do their own adjusting even if it takes a bit longer. This is a vital reflex mechanism similar to regulation of heart, blood pressure and digestion. If I swing a hand close to your face your eyes blink. I did not even touch you but you must respond. These are wonderful mechanisms.

With this understanding of the anatomical and physiological basis of another reflex approach you will have a very valuable tool for many occasions. One of the most obvious occasions will be with the torticollis patient whose ear and shoulder are nearly touching. The reflex correction of the spinal column there can be very dramatic and enable any further corrections to be accomplished very easily. Please do not try this as a complete revolution of your methods of practice, but rather as an additive of great value. Since this is a very definite neurological pattern of some predictability and is working through the cervical righting reflexes it is very closely related as a postural reflex technique to that of the Perianal Postural Reflexes which comprise another entire chapter of equal importance.

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A. E. Homewood, D
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